

Southern Utah Women's Health Center, P.C.

Name _____ Date _____ Age _____

Total number of pregnancies _____ Number of living children _____

Reason for seeing the physician today: _____

Menstrual Cycle:

Age periods began: _____

How many days from the beginning of one period to the beginning of the following period: _____

How many days do you flow? Total _____ Heavy _____

Do you cramp with your periods? Yes _____ No _____ Are your cramps: Mild Moderate Heavy (circle one)

Are your periods regular? Yes _____ No _____ If no, please explain _____

When was your last period? _____

When was your last mammogram? _____ Was it normal? _____

When was your last pap smear? _____ Was it normal? _____

What are you using for contraception? _____

Do you have a problem with your bladder or bowel functions? Yes _____ No _____. If yes, please explain briefly _____

Have you ever had pelvic surgery before? Yes _____ No _____ If yes, please list type of surgery and approximate date: _____

Past medical history:

List allergies to any medication: _____

List any previous surgeries that you have had: _____

List any medication you are currently taking and the dose: _____

If you have any problems with any or the following, please circle the item and give details

below:

- | | | |
|-------------------------|---------------------|-----------------|
| Abnormal pap smear | Rheumatic fever | Depression |
| Breast Lump or disorder | High Blood Pressure | Thyroid Disease |
| Lung disease | Herpes | Kidney Disease |
| Diabetes | Condyloma | Accident/Trauma |
| Heart Disease | Chlamydia/Gonorrhea | |
